

City of Jackson

Employee Dental Plan

This booklet contains only a general description of the benefits available to you under the City of Jackson Dental Benefit Plan (referred to in this booklet as Plan). The benefits described are subject to all the terms, conditions, limitations and definitions in the Plan. For specific information, the Plan is available for your study through your employer.

Use this space for information you'll need when asking about your coverage.

The person	in your Human Resource Department to contact about your coverage is:
Address:	
Phone:	
	& Blue Shield of Mississippi, Inc., is the Claims Administrator for the City of ntal Benefit Plan.
The Claims	Administrator's address is:
	3545 Lakeland Drive
	P.O. Box 1043, Jackson, MS 39215-1043
	Customer Service Phone: 1-601 -932-3704
My Identifi	cation Number shown on my Identification Card is:
The "Effect	ive Date" when my coverage begins is:

SCHEDULE OF BENEFITS DENTAL PLAN

PREVENTATIVE AND DIAGNOSTIC - PLAN PROVIDES 100%

Exams, Cleaning, X-Rays, Fluoride Treatments, Space Maintainers, Dental Sealants NO DEDUCTIBLE

BASIC - PLAN PROVIDES 80% - TYPE A

Fillings

Simple Extractions

Endodontics (Root Canal)

Periodontics (Gums)

Stainless Steel Crowns

Palliative Emergency Treatment

MAJOR BENEFITS – PLAN PROVIDES 50% – TYPE B

Crowns, Bridges, Dentures

ORTHODONTICS – PLAN PROVIDES 50% – TYPE C

WAITING PERIODS

Preventative and diagnostic – N/A

Basic - N/A

Major Benefits – 6 months

Orthodontic – 12 months

CALENDAR YEAR MAXIMUM

Preventative and Diagnostic, Basic, and Major:

PLAN PROVIDES \$1,000 (per Family Member)

Orthodontics:

PLAN PROVIDES \$1,000 (Per Eligible Child)

LIFETIME MAXIMUM BENEFIT

Orthodontics:

PLAN PROVIDES \$1,000 (Per Eligible Child)

CALENDAR YEAR DEDUCTIBLE

\$50 PER INDIVIDUAL (3 Deductibles Per Family)

(Waived for Preventative and Diagnostic)

DEFINITIONS

- 1. "Benefit Period" shall mean a period of one calendar year commencing each January 1.
- 2. "Claims Administrator" means the organization appointed by the Group to administer claims and to provide certain other services as described in an agreement between the Claims Administrator and the Group.
- 3. "Co-insurance" means the percent of a Covered Medical Expense that the Plan pays for benefits hereunder.
- 4. "Coverages"
 - a. "Employee-Only coverage" means coverage for an individual only.
 - b. "Employee and One Dependent Coverage" means coverage for the Employee and One Dependent.
 - c. "Family Coverage" means coverage for the Employee and Dependents subject to the conditions hereafter set forth.
- 5. "Covered Dental Expense" means Usual, Customary and Reasonable charges, as determined by the Claims Administrator, incurred on or after the effective date of coverage for such services and supplies as set forth herein and rendered or furnished to the patient by a Dental Practitioner subject to the Limitations and Exclusions.
- 6. "Deductible Amount" means the dollar amount, as shown in the Schedule of Benefits, of Covered Dental Expenses first hereunder incurred. No more than three (3) times the Deductible Amount must be satisfied in each Benefit Period for a family under Family Coverage. However, no family member may contribute more than the Deductible Amount to satisfy the maximum amount required of a family in each Benefit Period.
- 7. "Dependent" means the husband or wife of an Employee or any child of the Employee who is under twenty six (26) years of age; however, no person shall be deemed a Dependent unless the Dependent (1) was named in the application for the coverage, or (2) since execution of said application, has been reported to the Group in writing as a new or additional Dependent and has been approved as a Dependent in writing fixing the effective date of coverage and such effective date has occurred. The term "child" as used herein shall include any stepchild living in the same household with the Employee, legal ward and legally adopted child who depends upon Employee for support and lives with Employee in a regular parent-child relationship.
- 8. "Group" means City of Jackson, Mississippi.

- 9. "Participant" means a covered Employee or Dependent who has satisfied the provisions of Eligibility and has enrolled for coverage under this Plan.
- 10. "Dental Practitioner" means a Doctor of Medical Dentistry (D.M.D.) or a Dental Hygienist, when duly licensed and practicing within the scope of his/her license, is deemed to be a Dental Practitioner for purposes of this Plan.
- 11. "Plan" means this Dental Benefit Plan.
- 12. "Subrogation" means the substitution of the Plan in the place of the Participant with reference to a lawful claim, demand or right so that the Plan succeeds to the rights of the Participant in relation to the debt or claim, and its rights remedies or securities.
- 13. "Usual, Customary and Reasonable"
 - a. "Usual" means the usual fee which is charged for a given service by an individual Dental Practitioner in his personal practice that is his own usual fee; as to other providers, it is the usual charge made for services or supplies by the individual provider.
 - b. "Customary" means that range of usual fees charged by Dental Practitioners of similar training and experience for the same service within a given specified limited geographic area; as to other providers, "customary" means that range of usual charges made by providers for the same services or supplies within a given specific limited geographic area.
 - c. "Reasonable" means a fee which meets the foregoing "usual" and "customary" criteria applicable to Dental Practitioners or which is justifiable in the special circumstances of the particular case as determined by Claims Administrator.

ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF BENEFITS

Contributory Insurance

In order to cover yourself and your eligible dependents under this Plan, you must properly enroll in the Plan and pay the required cost through payroll deduction.

Who Can Be Covered

If you are a full time or permanent part time employee who works 20 hours per week, you are eligible to enroll in the Plan after one month of continuous employment. You must complete an application card.

You may include in your coverage your spouse, and your children up to age 26.

No person shall be deemed a Dependent unless the Dependent (1) was named in the application for the coverage, or (2) since execution of said application, has been reported to the Group in writing as a new additional Dependent and has been approved as a Dependent in writing fixing the effective date of coverage and such effective date has occurred. The term "child" as used herein shall include any stepchild living in the same household with the Employee, legal ward and legally adopted child who depends upon Employee.

When Your Coverage Begins

You should enroll when you meet the eligibility requirement of the Plan.

If you have properly enrolled and have met the Actively-At-Work requirement your coverage will begin on the date you complete one month of continuous employment.

Coverage For Your Dependents

If you are covered by the Plan, you can also cover your Eligible Dependents. They are defined in the paragraph below. If you and your spouse are both in the Eligible Group, either of you - but not both - may cover your children who are Eligible Dependents (See "Who Can Be Covered" in a prior section.)

Who Are Your Eligible Dependents

Eligible Dependents include your spouse unless you are legally separated or divorced, and your children under 26 years of age. The term "child" also includes any legally adopted child, and any stepchild who resides in the house of the employee and is permanently residing in the household of which the employee is the head.

When Coverage For Dependents Begins

It is important that you enroll for dependent coverage as soon as you are eligible.

Coverage for your dependents will begin on the date you become covered as an employee, provided you have eligible dependents and you have enrolled for dependent coverage. If you do not have eligible dependents when you first become covered, but legally acquire one or more at a later date, you will be eligible for dependent coverage on the date you acquire your dependents.

It is very important that you enroll your dependents on a timely basis to ensure coverage. Please contact the Personnel Department if you have any questions.

Once you have dependent coverage, any additional Eligible Dependents you may acquire will be covered automatically on the date you acquire them. However, you must inform, in writing, the Personnel Department of the name of the acquired dependent within 31 days of acquiring them.

For the purpose of the Plan, if a dependent child, who upon reaching 26 years, is an incapacitated child or physically handicapped and incapable of earning a living, then such child may continue to be covered as your Eligible Dependent. You must furnish written proof satisfactory to the Administrator of such incapacity, and that the child is chiefly dependent on you for support, within 31 days after the child's 26th birthday. The Third Part Claims Administrator may require you to furnish periodic proof of such child's continued incapacity and dependency. If such proof is not satisfactory to the Administrator, coverage for that child will end immediately.

When Your Coverage Terminates

Except as may be provided in BENEFITS UPON TERMINATION, all dental coverage will terminate at the earliest of the following:

- 1. the date the Dental Plan terminates:
- 2. the date you discontinue any required contributions;
- 3. the date you cease to be employed or otherwise eligible.

Your employer may temporarily continue your coverage if you are on leave of absence, laid-off, or employed part-time. Please contact your Personnel Office to discuss the continuation of your coverage.

IMPORTANT: If you voluntarily terminate your dental plan, you will not be allowed to reinstate the plan until a period of 24 months has elapsed.

Except as may be provided in BENEFITS UPON TERMINATION, all dental coverage on your dependent will terminate at the earliest of the following:

- 1. when your coverage as an employee terminates;
- 2. when you are no longer covered for dependent coverage;
- 3. the date any dependent ceases to be an eligible dependent;
- 4. the date you discontinue any required contributions;
- 5. the date the dependent child becomes covered as an employee under his or her new employer's dental plan;
- 6. the date of a divorce or legal separation from the employee;
- 7. the date the Dental Plan terminates.

CONTINUATION COVERAGE UNDER THIS PLAN AS REQUIRED BY COBRA

(Consolidated Omnibus Budget Reconciliation Act of 1986)

- 1. Employees and Dependents covered under the Group shall have the option of continuation of coverage under this Plan without proof of insurability if certain qualifying events occur.
 - a. Employees (and Dependents) for up to 18 months if coverage is lost due to one of the following qualifying events:
 - (1) Reduction of Employee's work hours;
 - (2) Voluntary termination of employment:
 - (3) Lay-off for economic reasons; and
 - (4) Discharge for misconduct (other than gross misconduct).

The 18 month period may be extended to 29 months for any qualified beneficiary who was disabled at the time of the qualifying event. The disability must be determined under the Social Security Act and notice of such determination must be received by the Claims Administrator within the 18 month period of Continuation Coverage.

If during the 18 month period of Continuation Coverage allowed because of termination, another qualifying event occurs, then the period of Continuation Coverage can be extended but for a period not to exceed 36 months from the date of termination of the Covered Employee due to an event as listed above.

- b. Dependents for up to 36 months if coverage is lost due to one of the following qualifying events:
 - (1) Death of the Employee;
 - (2) Separation or divorce of employee;
 - (3) Attainment of maximum age for coverage or marriage of a dependent child; and
 - (4) Entitlement of employee to Medicare if loss of coverage of Dependents results.
- 2. The Employee or Dependent has 60 days from the date the qualifying event occurs, or from the date the Employee or Dependent receives notice of the right to continuation coverage, whichever date is later, to elect continuation coverage under this Plan. If loss of coverage would otherwise result because of divorce, separation, Medicare eligibility of Employee, or

attainment of maximum age or marriage of the Dependent child, the Employee or Dependent has 60 days to notify the Employer from the date of the qualifying event or the date loss of coverage occurs, whichever is later. The Employee or Dependent must pay up to 102 percent of the actuarially expected cost for such continuation coverage except if Employee's or Dependent's continuation coverage is extended due to disability, in which case the Employee or Dependent must pay up to 150 percent of the actuarially expected costs for such continuation coverage from the 19th through the 29th months. Any premium payment owed from the date of the qualifying event must be paid within 45 days of the date the Employee or Covered Dependent elects Continuation Coverage. Any premium thereafter may be paid on a monthly basis when due (but no later than 30 days after the due date).

- 3. Continuation Coverage under this Plan may be terminated only upon:
 - (a) Termination of the Group's Dental Plan;
 - (b) Failure of employee or Dependent to pay the applicable COBRA premium;
 - (c) Eligibility for Medicare; or
 - (d) end of the 18, 29 or 36 month continuation periods.

COVERED DENTAL PROCEDURES

If Covered Dental Expenses are incurred by you or your covered dependents, benefits will be paid in accordance with the Schedule of Benefits as such is applied to the following Covered Dental Procedures:

Preventative and Diagnostic Services

1. Oral Examinations

- (a) Initial Examinations
 - limited to one during any 24 month period
- (b) Recall Examinations
 - limited to two per Calendar Year separated by an interval of at least 5 months

2. Radiographs and Radiographic Interpretations

- (a) Complete Series of Radiographs
 - limited to one during any 24 month period
- (b) Sets of Bitewing Radiographs
 - limited to two per Calendar Year separated by an interval of at least 5 months
- (c) Radiographs to diagnose a symptom or examine progress of a particular course of treatment

3. Required Consultations with Another Dentist

4. Prophylaxis and Topical Fluoride Applications

limited to two such treatments per Calendar Year separated by an interval of at least 5 months

5. Diagnostic Tests and Laboratory Examinations

6. Provision of Space Maintainers for Missing Primary Teeth

Benefits are limited to children up to age 19.

7. Sealants, subject to the limitations listed below:

- Benefits are limited to the first and second permanent molars.
- Application of sealants is limited to once every four years.
- Benefits are limited to children up to age 13.

TYPE A – Restorative, Surgical Procedures, Emergency or Palliative Services

1. Fillings

Amalgam, Composite, Acrylic or Equivalent

- 2. **Removal of Teeth** (Oral Surgery)
- 3. Preformed Stainless Steel Crowns and Repairs to Preformed Stainless Steel Crowns
- 4. **Endodontics**

Root Canal Therapy and Root Canal Fillings Treatment of Disease of the Pulp Tissue

5. **Periodontics**

Treatment of Disease of the Gum and other Supporting Tissue of the Teeth

- 6. Surgery and Related Anesthesia other than:
 - (a) Implants and Transplant, or
 - (b) Repositioning of the Jaw
- 7. Emergency or Palliative Services
 - (a) Emergency or Specific Examinations
- 8. Drugs which require a prescription by a physician or dentist to dispense and are approved by the United States Food and Drug Administration for the general use in treating the sickness or injury for which they are prescribed.

TYPE B – Prosthodontics Procedures

(6 Month Waiting Period)

- 1. **Inlays**
- 2. Crowns and Repair to Crowns, other than Preformed Stainless Steel
- 3. Repair of Bridges and Dentures

4. **Prosthodontics Services**

(After the person has been insured continuously for at least 12 months)

- Construction and insertion of Bridges or Dentures
- Construction and insertion of Bridges or Dentures to replace teeth previously replaced by an equivalent bridge or denture but generally only if at least 5 years have elapsed since that previous bridge or denture was initially constructed and inserted.

TYPE C – Orthodontic Procedures

(Provided the insured dependent is under age 19 when treatment is received) (12 Month Waiting Period)

1. **Interceptive, Interventive or Preventative Orthodontic Services**, other than Space Maintainers, which are covered under Preventive and Diagnostic Services.

2. Fixed Appliances

(Includes Diagnostic Procedures, Formal Full-Banded Treatment and Retention)

- (a) Permanent Dentition
- (b) Mixed Dentition
- (c) Primary Dentition

3. Removable Appliances

(Includes Diagnostic Procedures, Removable Appliance Therapy, and Retention)

- (a) Permanent Dentition
- (b) Mixed Dentition
- (c) Primary Dentition

LIMITATIONS AND EXCLUSIONS

Payment will not be made for the following:

- 1. Dental care not specifically included in the list of Covered Dental Procedures.
- 2. Dental care which is covered under any federal, state or governmental plan or law.
- 3. Dental care which is provided solely for the purpose of improving appearance, when form and function of the teeth are satisfactory and no pathological condition exists.
- 4. Charges for dentures lost, misplaced or stolen.
- 5. For construction and insertion of bridges or dentures more often than once in a 5-year period, unless such becomes necessary because:
 - A. it is needed to replace a bridge or denture, which has caused temporomandibular joint disturbances, and which cannot be economically modified to correct the condition, or
 - B. it is needed to replace a denture which was inserted shortly following extraction of teeth and which cannot be economically modified to the final shape required.

However, repairs of bridges or dentures are not subject to this Limitation and Exclusion.

- 6. For any charge in excess of the usual, customary and reasonable charge of the least expensive alternate service or material consistent with adequate dental care, when such alternate services or material are customarily provided.
- 7. Charges for appointments not kept, or for completion of claim forms.
- 7. Expenses related to services or supplies of the type normally intended for sport or home use, such as mouth guards.
- 9. Charges in respect of any dental care directly or indirectly due to or resulting from:
 - A. war, insurrection or the hostile action of the armed forces of any country.
 - B. participation in a riot, civil commotion or commission of a criminal offense.
 - C. any cause for which indemnity or compensation is provided under any Worker's Compensation Law or similar legislation.
- 10. Charges for Periodontal splinting.
- 11. Implants and transplants or repositioning of the jaw.

- 12. Charges for education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control.
- 13. Charges for drugs other than antibiotics and desensitizing medicines administered by the attending Dental Practitioner.
- 14. Charges for treatment by other than a Dental Practitioner.
- 15. Services received or supplies purchased outside the United States or Canada, unless the insured person is a resident of the United States or Canada and the charges are incurred while traveling on business or extended vacation.
- 16. Charges for appliances or restorations to increase the vertical dimensions or restore occlusion.
- 17. Charges for oral; surgery to correct congenital or developmental malformation.
- 18. Charges for replacement of teeth which are missing on the date coverage began for an insured person until the expiration of a 24-month period during which the insured person is continuously covered.
- 19. Charges incurred or treatment rendered unless there exists a requirement to pay irrespective of whether there is or is not insurance coverage, and irrespective of any other condition, provided that nothing herein shall be deemed to except from payment charges incurred or treatment rendered in an institution owned, operated by or contracted for or by a state or any political subdivision thereof.
- 20. Charges for facings on crowns, or pontics, posterior to the second bicuspid and the personalization and characterization of dentures.
- 21. Charges made for the replacement at any time of a bridge or denture which can be made to meet accepted dental standards of usability.
- 22. Deductible Amount as shown in the Schedule of Benefits.
- 23. Services rendered by a Dental Practitioner not practicing within the scope of his license.
- 24. For any injury growing out of a wrongful act or omission of another party for which injury that party or some other party makes settlement or is legally responsible; provided, however, that if the Participant is unable to recover from the responsible party, benefits of this Plan shall be provided.
- 25. Under more than one part of this Dental Plan or any other plan sponsored by the Employer, including any amendatory riders hereto, whether issued simultaneously herewith or later. Benefits will be allowed only on the basis of the part providing the greatest allowance.

COORDINATION OF BENEFITS

(Group and Individual Coverage)

1. APPLICABILITY:

- A. This Coordination of Benefits ("COB") section applies to This Plan when Participant or the Participant's covered dependent has dental care coverage under more than one plan. Only for the provisions of this section, "plan" and "This Plan" are defined below.
- B. If this COB section applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:
 - (1) shall not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another plan.
 - (2) may be reduced when under the Order of Benefit Determination Rules, another plan determines its benefits first.
- 2. DEFINITIONS: The following definitions only apply to the provisions of this section.
 - A. "plan" means any plan which provides services, supplies or equipment for hospital, surgical, medical, or dental care or treatment, including but not limited to, coverage under group individual insurance policies, non-profit health services plans, health maintenance organizations, subscriber contracts, self-insured group plans, prepayment plans, automobile or homeowners dental pay-plans, and medicare as permitted by federal law. This does not include, medicaid, hospital daily indemnity plans, specified diseases only policies, limited occurrence policies which provide only for intensive care or coronary care in the hospital.

Each plan or other arrangement for coverage is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

- B. "This Plan" means the part of the City of Jackson's Dental Benefit Plan and any Amendatory Rider thereto that provide benefits for dental care expenses.
- C. "Primary Plan"/"Secondary Plan", the Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense", means a necessary, reasonable, and customary item of expense for dental care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary because a covered person does not comply with the Primary Plan's provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.

- E. "Claim Determination Period", means the calendar year during which a person covered by This Plan is eligible to receive benefits under the provisions of This Plan.
- F. "Group Coverage" means contracts, plans or policies which can be obtained only because of employment with or membership in a particular organization, corporation, or other business entity.
- G. "Individual Coverage" means any plan, contract, or policy (other than Group Coverage) which provides benefits, care, or treatment for an illness or injury and which is sold directly to an individual.

The term "Individual Coverage" shall include any conversion contract or policy issued directly to a group member or dependent upon termination of group eligibility.

3. ORDER OF BENEFIT DETERMINATION RULES:

- A. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan if the other plan contains no provision for coordination of Benefits. If This Plan and another plan both contain Coordination of Benefit provisions, the plan that provides group coverage will be the Primary Plan. If both plans provide group coverage, or if both provide individual coverage, then This Plan is a Secondary Plan which has benefits determined after those of the other plan, unless:
 - (1) the other plan has rules coordinating its benefits with those of This Plan; and,

- (2) both those rules and This Plan's rules, in subparagraph (2) below, require that This Plan's benefits be determined before those of the other plan.
- B. This Plan determines its order of benefit payments, as follows:
 - (1) Non-dependent/Dependent: The benefits of the plan which covers the person as an employee, or member (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.
 - (2) Dependent Child/Parents No Separated or Divorced: Except as stated in subparagraph B(1) below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents".
 - (a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - (b) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
 - However, if the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
 - (3) Dependent Child/Separated or Divorced Parents: If two or more plans cover a person who is a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (a) first, the plan of the parent with custody of the child;
 - (b) then, the plan of the spouse of the parent with custody of the child; and
 - (c) finally, the plan of the parent not having custody of the child.

However, if specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply when any benefits are actually paid or provided before the entity has that actual knowledge.

- (4) Joint Custody: If the specific terms of a court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in B(2).
- (5) Active/Inactive Employee: The benefits of a plan which covers a person as an employee who is neither laid off nor retired, or as the employee's dependent, are determined before those of a plan which covers that person as a laid off or retired employee or as the employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.
- (6) Longer/Shorter Length of Coverage: If none of the above rules determine the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter time.

4. EFFECTS ON THE BENEFITS OF THIS PLAN:

- A. This Paragraph 4. applies when, in accordance with paragraph 3., This Plan is Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced, as described in this section. Such other plan or plans are referred to as "the other plans" in B immediately below.
- B. Reduction in This Plan's Benefits.

The benefits of This Plan will be reduced when the sum of:

- (1) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB Endorsement; and
- (2) the benefits that would be payable for the Allowable Expenses under the other plan in the absence of provisions with a purpose like that of this COB Endorsement, whether or not claims are made;

would be more than those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION:

Certain facts are needed to apply these COB rules. The Claims Administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organizations or person. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Contract must give the Claims Administrator any facts it needs to pay the Claim.

6. FACILITY OF PAYMENT:

A payment made under another plan may include an amount which should have been paid under This Plan. The Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case the payment made shall be deemed to be the reasonable cash value of any benefits provided in the form of services.

7. RIGHT OF RECOVERY:

If the amount of the payments made by the Claims Administrator is more than it should have paid under this COB provision, it may recover the excess. It may get such recovery or payment from one or more of:

- A. the persons it has paid or for whom it has paid;
- B. insurance companies; or
- C. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL CONDITIONS

- 1. The Claims Administrator shall not be liable for or on account of any fault, act, omission, negligence, malfeasance or malpractice on the part of institution, or any agent or employee thereof, or on the part of any other person participating in or having to do with the care or treatment of Participant.
- 2. Any notice required to be given by Claims Administrator to Participant hereunder shall be deemed to be given and delivered when deposited in the United States mail, postage prepaid, addressed to Employee at his address as the same appears on the records of Claims Administrator, or to the Group at the address as the same appears on the records of Claims Administrator.
- 3. Coverage under This Plan shall be effective from January 1, 1995.
- 4. Each Participant receiving care under this Plan authorizes and directs any Dental Practitioner to furnish to Claims Administrator at any time upon its request all information, records, copies of records or testimony relating to attendance, diagnosis, examination or treatment, and by such authorization, expressly waives any and all laws providing for privileged communications between Dental Practitioner and patient. Such authorization and waiver, and compliance therewith by each Dental Practitioner affected, shall be a condition precedent to rights to benefits to each Participant covered hereunder, and no benefits shall be provided in any case where such authorization and waiver is not given full effect. Claims Administrator will hold such information, records or copies of records as confidential except where in its discretion the same should be disclosed.
- 5. Notice and Proof of Loss.
 - A. As a condition precedent to any right of action hereunder, written notice upon which claim is based must be given to Claims Administrator within ninety days after the end of the Benefit Period for which indemnity is claimed, and written proof of loss for which claim is made must be furnished to Claims Administrator within ninety days after the end of the Benefit Period for which indemnity is claimed.
 - B. Upon failure of Participant to so notify Claims Administrator or furnish proof or loss, payment may be refused or a percentage of the regular payment provided may be paid at the option of Claims Administrator; provided, however, failure to give notice of proof of loss within the time provided shall not invalidate claims if it be shown that compliance with this provision was not reasonably possible and that notice of claim was given as soon as reasonably possible.
 - C. Claims Administrator, upon receipt of such notice, will furnish to the Participant such forms as are usually furnished by it for filing proof of loss. If such forms are not

furnished within fifteen days after Claims Administrator receives such notice, the Participant shall be deemed to have complied with the requirements as to proof of loss upon submitting within the time fixed for filing proof of loss, written proof covering the occurrence, character and extent of loss for which claim is made.

6. A Participant has 60 days, from the date of receipt of notification of the Claims Administrator's action on his claim, to request a review of any benefits denied in whole or in part.

To request a review, the Participant must write to the Claims Administrator, stating the issue to be reviewed and attaching to the request for review pertinent records and other information that the Participant offers in support of his claims. Participant may also request a description of any pertinent records that the Claims Administrator relied on in making its original decision to deny the claim in whole or in part.

A disposition of the claim will not be deemed final until such time as written decision is rendered, such decision to be rendered within 60 days after the request for review is received, unless records are requested, in which case the decision will be rendered no later than 120 days after the request for review is received. When a request for review is made later that 60 days after notification of the Claims Administrator's action, the foregoing time limitations shall not apply, but the review shall be made promptly while giving priority to requests made within 60 days. The Participant will receive a written decision stating the specific reasons for its final decision with specific references to pertinent Plan provisions.

TERMINATION OF PLAN

This Plan may be terminated at any time by the Group. Termination of this Dental Plan will immediately terminate all rights, provisions and benefits provided here in and all Participants' coverage will also terminate as of such termination date. However, any benefits incurred prior to the Dental Plan termination date shall be payable as if the Dental Plan had remained in force.

AMENDMENT OF PLAN

This Dental Plan may be amended or modified at any time by the Group, without notification to the Participants. Such amendment or modification will apply to all covered persons, covered benefits, exclusions, limitations, etc. for any covered dental expense occurring on or after the effective date of the amendment.

NOTICE

For employers having 20 or more active employees, federal law and regulations require that, each active employee, age 65 or older, and each active employee's spouse, age 65 or older, may elect to have coverage under the group plan or under Medicare.

- a. Where such employee or such spouse elects coverage under the group plan, the group plan will be the primary payor of benefits with the Medicare program the secondary payor.
- b. This group plan will not provide benefits to supplement Medicare payments for an active employee age 65 or older or for a spouse age 65 or older of an active employee where such employee or such spouse elects to have the Medicare program as the primary payor.

Under federal law if an active employee under age 65 or an active employee's dependent under age 65 is covered under a group plan of an employer with 100 or more employees and also has coverage under the Medicare program by reason of social security disability, the group plan is the primary payor and Medicare is the secondary payor.

Claims Administered By



BlueCross BlueShield of Mississippi

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.

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